GLOBAL COMMISSION ON DRUG POLICY

POSITION PAPER

DRUG POLICY AND DEPRIVATION OF LIBERTY

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GLOBAL COMMISSION ON DRUG POLICY

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DRUG POLICY AND DEPRIVATION OF LIBERTY

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Inmates of the Mafanta Prison in Magburaka, Sierre Leone. In 2016, Sierra Leone's Human Rights Commission lashed the squalor and lack of rehabilitative or educational programmes in the country's prisons as «inhumane.» © SAIDU BAH/AFP/Getty Images 2018

FOREWORD

Prison is the most glaring expression of the failures of prohibition-based drug policies: the failure to reduce drug demand, despite 30 years of states punishing consumption; the failure to reduce drug supply and the power of transnational organized crime, despite an international drug control regime that has existed for over a century. Above all, incarceration is the epitome of the human cost of these failed policies.

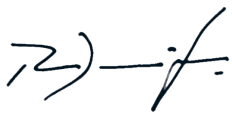
The global prison population has soared in the last three decades, largely because of the repressive system established by the international drug control regime and the national laws that derive from it. In our view, deprivation of liberty is the wrong response to drug use, as well as to non-violent petty crime generated by the illegal market. This is why the Global Commission on Drug Policy has been calling, since its establishment, for the decriminalization of illegal drug consumption, as well as for alternatives to incarceration for offenders who were forced to engage in illegal activities, whether by lack of other options to make a living or coercion by criminal organizations.

Prison is inevitably an ineffective response because it does not take into account the social and psychological root causes of problematic drug consumption, nor does it consider the economic and social marginalization of traditional coca, cannabis or poppy cultivators, nor of women who smuggle small quantities of drugs, street dealers, or spotters. Prison is also the wrong response because people who are incarcerated are vulnerable, exposed to risks for which they are not well-equipped, and are dependent on those who manage their daily lives. Herein lies the paradox of incarceration: the deprivation of liberty inherently means the inability to think for and to support oneself, in an environment where the risk of violence is high, living in promiscuity and isolation from friends and relatives.

Even though they are banned, the reality is that illegal drugs and other psychoactive substances are largely prevalent in prison. Thus, if incarcerated people consuming drugs also lack access to the means that would allow them to reduce the harms associated with use, they will be exposed to health risks that are far greater than they might otherwise be outside of prison. It is therefore essential to offer the full range of treatment options for dependency, including opioid maintenance therapies, and to allow access to harm reduction means. All these measures that have proven to be effective in protecting people against the transmission of HIV, hepatitis and tuberculosis need to be implemented in detention facilities, facilities that are by themselves more "pathogenic," a situation aggravated by overcrowding. Special attention also needs to be given to the risks to which people who use drugs are exposed when released from prison, as the transition towards their previous lives is marked by higher overdose rates than in the general population.

There are a variety of forms of detention: prisons and jails for pre-trial detention or the execution of a sentence, detention centers for refugees and illegal migrants awaiting decision on their asylum status, and compulsory drug treatment centers. Human rights must be upheld as much in these facilities as in the community at large: people who are incarcerated need to be protected from cruel, inhuman, and degrading treatment, and need to have access to care, prevention, and effective treatment, based on patient consent and confidentiality. To guarantee these rights for incarcerated people is the shared responsibility of health professionals, prison staff, and state authorities – those who legislate, judge, or allocate budgets or provide funding – all share a responsibility to guarantee these rights to people who are incarcerated. No punishment or prison sentence cancels these rights.

The Global Commission, while it calls for more sustainable and far-reaching reforms in drug policy, can no longer ignore the current situation of incarceration and related human rights violations. This situation urgently calls for political, correctional, and medical authorities to face up to their responsibilities.



Ruth Dreifuss

Former President of Switzerland

EXECUTIVE SUMMARY

Since its establishment, the Global Commission on Drug Policy has been calling for the decriminalization of illegal drug consumption, as well as for alternatives to incarceration for low-level non-violent offenders. Today, more than 10 million people are incarcerated worldwide. One in five is incarcerated for drug-related offenses and of these, 83 per cent serve sentences merely for drug possession for personal use. The commission views incarceration as an expression of the failures of prohibition-based drug policies to achieve their goals, and of the failure to implement policies that would prioritize the health and rights of individuals and communities over criminal justice approaches.

Prison is the consequence of the failures of drug policy: failure to reduce drug demand, drug supply, and the power of transnational organized crime. When a state undertakes a deprivation of liberty, it has a duty of care and special responsibility towards those held in detention. Many states, however, fail to do so in a number of ways.

Over-incarceration occurs when a state's criminal justice policy provides for incarceration for minor non-violent offenses that could otherwise be handled through a fine, probation, administrative penalties, or day parole. Over-incarceration is also a result of disproportionately long sentences for minor non-violent offenses. In fact, most people incarcerated for drug-related offenses are either people who use drugs or low-level dealers. In addition, some states provide for mandatory pre-trial detention for all drug-related offenses, whether the offenses are minor or high-level in character. Ethnic minorities are far more likely to be arrested for drug-related offenses, convicted, and sentenced to prison.

This is closely linked to overcrowding, which occurs in more than half the countries in the world. It creates a significant obstacle to ensuring a minimum standard of treatment for people in detention and the protection of their human rights. These human rights are mandated by international law and treaties, and which states are obliged to apply to their citizens whether in the community or in prison, include the right to health; the right to be treated humanely and with respect for one's dignity; the right to life; the right to security of the person; the prohibition of torture and other cruel, inhumane, and degrading treatment or punishment; the right to privacy and adequate accommodation; and the right to food, water, and sanitation. Prison overcrowding contributes to increased rates of violence, mental health problems, self-harm, and suicide. It creates a high-risk environment for the transmission of HIV, hepatitis C and tuberculosis, entailing wider public health implications for society once people are released from incarceration.

These practices continue, even though imprisonment has been shown to be counterproductive in the rehabilitation and reintegration of those charged with minor offenses. With regard to drugs, detention is not scientifically recognized as an effective way of getting people to discontinue use; in fact, drug use in prison is statistically higher than outside: approximately 20 per cent of people imprisoned worldwide use drugs, compared to 5.3 per cent of the general population. People can be initiated into drug use while in prison, or initiated into the use of different and more harmful types of drugs. It has also been estimated that 56-90 per cent of people who inject drugs have been incarcerated at some point in their lives.

States have the responsibility to protect the right to health of those deprived of liberty, and incarcerated people should enjoy the same standards of health care as those available in the community. This applies to everyone on a non-discriminatory basis, including people who use drugs and drug-dependent people. States have largely failed to meet this standard. For example, in 2016 only 52 countries provided opioid maintenance treatment in prisons. The situation is worse for needle and syringe programs, provided in prisons in only 10 countries, as resistance to their im-

plementation remains high among authorities and prison staff. HIV, hepatitis C, and tuberculosis treatment are also often less available in prison environments.

Prisons are high-risk environments for communicable diseases such as HIV, hepatitis C, and tuberculosis. Tuberculosis is one of the fastest-growing epidemics among prison populations and one of the main causes of death, particularly in low- and middle-income countries. Incarceration rates and tuberculosis incidence in the general population have been found to be directly correlated. Prisons, drug use, and HIV are all independent risk factors for the development of tuberculosis and amplify each other into synergistic comorbid phenomena.

A further problem is the continuity of treatment and care, both for people who were receiving treatment when entering prison – including for HIV, tuberculosis and other infectious diseases, and drug dependence – and for those requiring care when they leave.

These issues are compounded in countries that detain people for drug-related offenses without registering or charging them, or bringing them promptly before a judge. Some even use compulsory drug detention centers, where individuals who use (or who may only be suspected of using) drugs are confined against their will with the objective of constraining them to abandon drug use. Sources estimate that over 600,000 people are detained in these centers in at least 15 states. Neither detention nor forced labor have been recognized by science as treatments for drug use disorders. Relapse rates for people released from compulsory drug detention centers are very high, and higher than for those who undergo voluntary treatment. Drug treatment should not involve the criminal justice system.

RECOMMENDATIONS

To address this "perfect storm" of prison overcrowding and inadequate health care for a vulnerable group of people who use drugs deprived of their liberty, the Global Commission on Drug Policy recommends that:

- States must end all penalties – both criminal and civil – for the possession and cultivation of drugs for personal consumption.
- States must end disproportionate sentencing and punishment for drug-related offenses, and recognize that over-incarceration impacts negatively on public health and social cohesion.
- States must ensure primary health care is available and the right to health is applicable to all people on a non-discriminatory basis, including people detained against their will.
- Practices that violate human rights of people deprived of liberty must be forbidden, their perpetrators brought to justice, and compensation awarded to victims as provided for in human rights law.

A BRIEF OVERVIEW OF INCARCERATION AND DRUGS

Since its establishment, the Global Commission on Drug Policy has been calling for the decriminalization of illegal drug consumption, as well as for alternatives to incarceration for low-level non-violent offenders.

Today, more than 10 million people are incarcerated worldwide. One in five is incarcerated for drug-related offenses and of these, 83 per cent serve sentences merely for drug possession for personal use. The commission considers incarceration as an expression of the failures of prohibition-based drug policies to achieve their goals, and of the failure to implement policies that would prioritize the health and rights of individuals and communities over criminal justice approaches.

When a state undertakes a deprivation of liberty, it has a duty of care and special responsibility towards those held in detention. Failure to fulfil this duty may engage the responsibility of the state under national and international law.[1,2]

PRISONS WORLDWIDE

As of September 2018, there were an estimated 10.74 million people incarcerated worldwide, including those in pre-trial detention – prisons representing the facilities where the highest numbers of people are deprived of liberty worldwide.[3,4]

Since the year 2000, the world prison population has increased by 24 per cent, which is approximately in line with world population growth. However, there have been considerable variations in the increase in prison populations by regions, with increases of 86 per cent in Oceania, 41 per cent in the Americas, 38 per cent in Asia, and 29 per cent in Africa. In Europe, there has been a decrease in prison populations by 22 per cent, largely as a result of a decrease in prison populations in the Russian Federation and Eastern and Central Europe, attributable in large part to a sharp drop in serious crime rates.[5]

The largest increases in prison populations have taken place in South America (175 per cent) and Southeast Asia (122 per cent).[6]

The 10 countries with the largest number of incarcerated people, not counting administrative detention, are the United States (2.1 million), China (1.65 million, not including people in pre-trial detention), Brazil (690,000), the Russian Federation (583,000), India (420,000), Thailand (364,000), Indonesia (233,000), Iran (230,000), Mexico (204,000), and the Philippines (188,000).[7]

Over-incarceration

Incarceration should be used only when it is necessary to meet the needs of security and safety of people or when other non-custodial measures are not adequate, and it should be strictly proportionate to the offense committed.[8] Over-incarceration occurs when, for example, a state makes excessive use of custodial or pre-trial detention and does not respect human rights norms in the criminal justice process.[9] It can also occur when a state's criminal justice policy provides for incarceration for minor non-violent offenses that could be handled through a fine, probation, administrative penalties, or day parole.

Diverting minor non-violent cases out of the system altogether may be appropriate in many instances, particularly for cases involving drug use or possession of drugs for personal use, or other minor drug-related offenses and in cases of people with mental health issues, children, and mothers with dependent children. The UN Office on Drugs and Crime (UNODC) has noted that imprisonment has been shown to be counter-productive in the rehabilitation and reintegration of those charged with minor offenses, as well as for certain vulnerable populations.[10] Better access to legal representation and legal aid may also help reduce over-incarceration.[11]

Prison overcrowding

Prison overcrowding, defined as countries having a prison population of more than 100 per cent of official capacity, is a reality in more than half the countries in the world. Moreover, in more than 20 per cent of countries there is severe prison overcrowding, with prison populations at more than 150 per cent of official capacity.[12] Prison overcrowding is a key factor leading to inadequate prison conditions, and creates a signi-

ficant obstacle for prison authorities to fulfil their obligations to ensure access to health services for people in detention and the protection of their human rights. The rights of incarcerated people that may be undermined by prison overcrowding include the right to health; the right to be treated humanely and the right to respect for one's dignity; the right to life; the right to security of the person; the prohibition of torture and other cruel, inhumane and degrading treatment or punishment; the right to privacy and adequate accommodation; and the right to food, water and sanitation.[13]

Prison overcrowding overstretches prison resources and may result in inadequate staffing levels that can lead to an inability to ensure the right to security of incarcerated people and to protect people from inter-prisoner violence. It may further result in serious tensions between staff and incarcerated people, which can infringe on respect for disciplinary rules and lead to disturbances, hunger strikes, and riots to protest conditions of imprisonment.[14]

Overcrowding can result in situations where detained people sleep in shifts or on top of each other, share beds, or tie themselves to window bars so that they can sleep while standing. Prison overcrowding can also contribute to increased rates of violence, mental health problems, self-harm, and suicide. It can compromise educational and vocational programs, recreational activities, and the goal of rehabilitation of prisoners and preparing them to reintegrate successfully into society on release.[15] Prison overcrowding can create a high-risk environment for the transmission of HIV, hepatitis C, and tuberculosis, entailing wider public health implications for society once people are released from incarceration.[16]

"Studies show that the US has among the highest rates of drug use in the world. But even as restricting supply has failed to curb abuse, aggressive policing has led to thousands of young drug users filling American prisons, where they learn how to become real criminals."

George P. Shultz, Honorary Chair of the Global Commission on Drug Policy.[1]

CUSTODIAL AND PRE-TRIAL DETENTION

Custodial and pre-trial detention refer to two slightly different situations. Custodial detention refers to a situation where people are arrested and subsequently released without being charged. The duration of this type of confinement in most countries is between 24 and 72 hours, a period of time that conforms to international human rights law. In a significant number of states, large numbers of people are arrested, detained, and subsequently released relatively quickly without being charged.[17]

Pre-trial detention is a situation where a person has been arrested and charged with a crime, and a judge has determined that the charged individual should be held in pre-trial detention while awaiting trial, rather than being released pending trial. It is not the general rule that a person arrested and charged shall remain in pre-trial detention, and the UN has said that, "under international law, detention prior to conviction must be the exception, not the rule."[18]

Custodial detention: a period of vulnerability

If people are arrested and not released promptly without being charged, human rights law obliges states to charge the arrested person with a criminal offense and to bring them within a short time before a judge to determine whether the arrest was arbitrary. For an arrest to be lawful, there must be a basis in criminal law for the arrest, and applicable legal procedures for the arrest must be observed.[19] The UN High Commissioner for Human Rights has expressed concern that in some countries, people were arrested for drug-related offenses and were neither registered, nor charged, nor brought promptly before a judge.[20,21]

In custodial detention, a serious concern for people arrested for drug-related offenses who have not yet been charged with any crime is that they may be subjected to torture and/or cruel, inhumane, or degrading treatment or punishment. In many countries, law enforcement relies heavily on confessions as evidence that an individual has committed

[1] *NYT, 31 Dec 2017*

an offense. Therefore, law enforcement may arrest someone on only a suspicion that a person has committed a drug-related offense, and may use brutal withdrawal symptoms and other forms of punishment until the person confesses to a crime. Torture and other forms of ill treatment are also used to obtain information about other people who use drugs and about traffickers involved in the drug trade.[22]

Pre-trial detention: the source of overcrowding

Excessive use of pre-trial detention for drug-related offenses has made a significant contribution to prison overcrowding. It has been reported that law enforcement authorities in some countries have targeted areas at or near drug treatment centers in order to make arrests. People who use drugs may constitute an easy target for arrest for law enforcement officials who feel pressured to meet certain arrest goals or quotas. It has also been reported that people who use drugs may be harassed by law enforcement officials for money or sex to avoid arrest.

Factors considered in determining whether a person is released or held in pre-trial detention include whether the individual is potentially a flight risk, whether there is a danger of destruction of evidence, and whether there is a reasonable likelihood that the person may commit another crime. If the person is released pending trial, guarantees may be required so that the person appears at all stages of judicial proceedings. The Human Rights Committee has determined that pre-trial detention should not be mandatory for any particular criminal offense and that it should not be ordered for a period based on the potential sentence for the alleged crime.[23] The Inter-American Commission on Human Rights has also declared the practice of automatic pre-trial detention for a specific crime to be a human rights violation.[24] All of these practices should be considered as arbitrary arrest and detention, and as causing an increase in the number of people deprived of liberty. It has also been reported that people in poor or marginalized areas where there is often more street activity may also be targeted or "over-policed." Reports indicate that law enforcement action against people who use drugs and micro-traffickers disproportionately targets minorities, women, and the poor.[25] The Committee on the Elimination of Discrimination against Women expressed concern at the number of women imprisoned for drug-related offenses in the United Kingdom, and observed that this may be a reflection of women's poverty.[26] In some states, pre-trial detention for drug-related offenses can be for a period of months or even years. Some countries, such as Bolivia, Brazil, Ecuador, and Mexico, provide for mandatory pre-trial detention for all drug-related offenses, whether the offenses are minor or high-level in character.[27]

"The widespread criminalization and punishment of people who use drugs, the over-crowded prisons, mean that the war on drugs is, to a significant degree, a war on drug users – a war on people."

Kofi Annan, member of the Global Commission on Drug Policy, 2016.[2]

PEOPLE WHO USE DRUGS AND PRISONS

It has been estimated that approximately one in five people in prison worldwide, or over 2 million people, are incarcerated for drug-related offenses.[28] Of the latter, approximately 83 per cent are serving sentences for drug possession for personal use.[29]

Most other people incarcerated for drug-related offenses are low-level dealers or micro-traffickers. In the United States, the majority of small-scale drug offenders have no history of violence.[30] In Colombia, it was estimated that only 2 per cent of people convicted for drug-related offenses were medium to high-ranking figures in the drug trade.[31] Over-incarceration for drug-related offenses is a result of disproportionately long sentences for minor non-violent offenses. In many countries, mandatory minimum sentences and disproportionately long sentences have resulted in sentences for drug-related offenses that are longer than for murder, rape, kidnapping, or bank robbery.[32]

[2] *Der Spiegel, 22 Feb 2016*

Testimony

Nayeli – Bolivia

I was five years old when I moved into a prison for the first time. They caught my father transporting two and a half tons of cocaine base paste. My whole family, all seven children, moved in with my dad. We would go to a daycare center outside from 7am until 5pm. We lived there for seven years, the full length of his sentence.

When he got out, he couldn't feed all of us. In 8th grade, I decided to get a part-time job in a cumbia music band. Later, I quit school to work full-time in music to help provide for my family. Unfortunately, a band member raped me; it was the first time I had had sex, but I got pregnant. The baby's father rejected him, moved to Spain, got married and started a family. When he returned several years later, he took my son away from me.

My next partner beat and cheated on me, but I thought it might be different if we moved to Argentina. I was wrong. I had another son there, so I took him back to Bolivia and began working as a secretary for a taxi company. It didn't pay much. After a while, someone offered me 1,500 USD to swallow "small capsules" and take them to Chile in my stomach. I took 900 grams of cocaine my first time. I did it twice.

In 2014, they arrested me at my house while I was getting ready for a third trip. I qualified for a government pardon, intended to ease prison overcrowding, so I only spent four months in prison.

After my release, I got a loan to start a small business, but it didn't go well. I couldn't pay it back, so I agreed to go back to Chile with three large packages of cocaine base paste taped to my legs for 2,000 USD. I never made it out of Cochabamba, my friend's boyfriend told the police what we were doing. I went back to prison in 2015 and got an eight-year sentence. As a repeat offender, I no longer qualify for pardons. I live there now with my second son.

Life in prison is really sad, and those of us that have no one feel lonely all the time. My mother used to visit, but she passed away, and I couldn't go to her funeral. I ask myself, what have I done to deserve this? I know that a lot of people suffer because of drugs, but I am not a murderer.

Life in prison is hard. Sometimes there's no water to shower or wash your hands or clothes. I don't always have enough money to buy food for my son and me. People occasionally donate fruit and vegetables, but inmates fight to get them. If you need to go to the hospital, you have to work through the system to get a special permit. You can't go without it, you have to prove that you're sick.

When I get out, I want to move far, far away from here. I don't want to stay in Cochabamba. I want to move somewhere else with my younger son and start a new life. I haven't seen my oldest son since 2015. He doesn't know I'm in prison, and I don't want him to find out. I'm ashamed. I want to get custody of him after my release. There are so many things I want to tell him. I hope he can forgive me.

The "war on drugs" and international conventions

In the United States, the high rate of incarceration for drug-related offenses dates back to the "war on drugs" that began in 1971. In 1980, there were 40,900 people incarcerated for drug-related offenses in federal and state prisons; by 2015, the number had grown dramatically to 469,545.[33] This substantial increase in incarceration for drug-related offenses was further encouraged by the adoption of the UN Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances of 1988. This convention required criminalization of the personal use of drugs, as well as the possession or acquisition of drugs, unless it was incompatible with a state's constitutional principles and the basic concepts of its legal system (Article 3 (c)(1)). It also required the criminalization (but without providing for non-application in cases of non-conformity with a state's constitutional principles and the basic concepts of its legal system of production) of any "manufacture, extraction, preparation, offering, offering for sale, distribution, sale, or delivery of illicit drugs" (Article 3(a)(1)).

Although drug use rates are similar between ethnic minorities and the majority populations in Australia, Canada, the United States, and the United Kingdom, ethnic minorities are far more likely to be arrested for drug-related offenses, convicted, and sentenced to prison, according to studies conducted on the subject.[34] It has been posited that, in addition to racial discrimination, this is also due to heavy policing of poor neighborhoods and those areas where ethnic minorities are concentrated.[35]

The international drug conventions provide for diversion for drug-related offenses of a minor nature, if compatible with a state's constitutional principles and the basic concepts of its legal system.[36] Nevertheless, and despite the fact that both UNODC and the World Health Organization (WHO) have called for diversion of people with problematic drug use from the criminal justice system,[37] many countries continue to punish minor drug-related offenses severely, including drug use and possession for personal use. Many also set low thresholds for qualifying drug possession as a trafficking offense, which inevitably carries much stiffer criminal sanctions.[38]

Drug use among incarcerated people

Drug use is widespread in places of incarceration. It has been estimated that approximately 20 per cent of people imprisoned worldwide use drugs, much higher than the 5.3 per cent of the general population.[39] Drug use among those incarcerated is not limited to those who have been convicted for a drug-related offense, but can also be prevalent among those who were imprisoned for offenses unrelated to drugs.[40]

Prisons may be a setting where a person is initiated into drug use, or into the use of different and more harmful types of drugs. The type of drugs used may be influenced by the lack of preferred substances within prison or because a particular substance can be concealed more easily to avoid detection. In one study, it was found that one-third of incarcerated people started to use a drug while incarcerated which they had not used before, with the most common substance being heroin.[41]

It has also been estimated that 56-90 per cent of people who inject drugs have been incarcerated at some point in their lives.[42] In Eastern Europe and Central Asia, for example, people who inject drugs represent 30-80 per cent of prison populations.[43] It is estimated that drug injection among people in prison ranges from 2 to 38 per cent in Europe, 34 per cent in Canada, and 55 per cent in Australia.[44]

As noted before, the majority of incarcerated people tend to come from poor communities or marginalized ethnic groups. In addition, people experiencing incarceration tend to suffer from high levels of physical and psychiatric disorders, the latter including antisocial and personality disorders, depression, or post-traumatic stress disorder. Given that some or all of these factors weigh on people who have been incarcerated, drug use and drug dependence are disproportionately higher in prisons than in the general population.[45]

Testimony

Yatie Jonet – Malaysia

I dropped out of school when I was just 15, presumably because my parents did not know enough about the issues affecting teens and how to deal with them. As a high school dropout, I took my own path and, unaware of the consequences, I started consuming drugs everyday, with different forms and methods of consumption, most of them harmful. I had no idea, there was no information available. I injected drugs for two years and ended up contracting hepatitis C in 2013, four years after I was last released from detention centers.

I would resort to petty crime to support my daily intake and started selling drugs after my partner was detained and jailed for a drug offense. I often had no choice but to bribe local law enforcement officers with money and sex so I wouldn't end up in jail. I have said nothing until today about this out of fear of being killed or forcefully disappeared.

But of course, I was often arrested. I would be detained in a lockup for a month, a month and a half, without any access to treatment, before being sent to prison. I have been in and out of prison, carrying a lifetime criminal record because of my drugs offenses, the same as with other users. We're an easy target to catch again and again. As a person using drugs, you are seen as the public enemy number one in Malaysia.

In addition to not having access to proper health care, I was unable to be a mother to my son. I lost the essence of motherhood, unable to feel and nurture motherly instincts because I was consistently separated from him, either because I was afraid of losing my supply of drugs by staying with my family rather than my boyfriend/dealer, or when I was in prison.

Finally, I managed to stop injecting drugs, working as an outreach worker passionately sharing essential information about harm reduction programs and emphasizing treatment and health care, as well as sharing my personal experiences. After years of serving my community with a civil society organization, I became who I am today despite being neglected, rejected for being myself. I am now pursuing my goals advocating for an urgent need to reform global drug polic and protect fundamental human rights by shaping a nation with that offers an enabling and safe environment for our future generations.

In general, almost everyone was against my openness about my active drug use and I was constantly labelled a "liberal", even amongst those in my community so close to my heart, who came from various backgrounds and consisting of people who formerly used drugs and live with lifetime criminal records and with infectious diseases . And even though they have completely stopped using drugs, they still are unaware of the negative consequences of the punitive drugs policy that enforces zero tolerance and abstinence-only approaches.

I continue to dream about getting a certificate or something that would allow me to live in dignity. For a person who uses drugs, being acknowledged as a human being and not just an object of study in drugs and drug use would already be a victory.

HEALTH AND DEPRIVATION OF LIBERTY

INFECTIOUS DISEASES PROLIFERATE IN PRISONS

HIV and hepatitis C fueled by incarceration

Injecting drug use is known to be an independent risk factor for acquiring blood-borne infections such as HIV and hepatitis C. For instance, injecting drug use is the driving force of the HIV epidemic in Eastern Europe and Central Asia, the only regions in the world (with the Middle East and North Africa) where the number of new HIV cases continues to increase. Around 60 per cent of these new cases are co-infected with hepatitis C.[46] Prisons are high-risk environments for spreading communicable diseases such as HIV, hepatitis C, and tuberculosis.

Treatment options such as opioid substitution therapy (OST),[47] or harm reduction measures such as needle and syringe exchanges, are very limited (if available at all) in prison systems worldwide. Resistance to their implementation remains high among authorities and prison staff.[48] Consequently, people who have been incarcerated are forced to share needles and syringes, thereby creating the conditions for further spread of HIV and hepatitis C. In Canada, the prevalence of HIV in prisons is estimated to be 10 times higher than in the general population, whereas the prevalence of hepatitis C is 30-39 times higher.[49] In Ukraine, it was reported that almost 57 per cent of incarcerated people were injecting drugs in prison, each needle/syringe being shared by a mean 4.4 people who inject drugs.[50] Incarceration is implicated as a driver of HIV transmission among people who inject drugs. Prevalence among incarcerated people who inject drugs in the country exceeds 20 per cent, and at least 28-55 per cent of all new HIV infections can be attributed to incarceration.[51] A history of incarceration has been shown to be associated with HIV and hepatitis C infections.[52]

The availability of effective antiretroviral treatment (ART) in the context of HIV infection varies in settings where resources and reach are limited. However, in prisons it is available to a much lesser extent, as is access to health care in general.[53] Without ART, in the presence of drug use under poor living conditions combined with overcrowding and promiscuity, HIV infection may progress rapidly, putting people living with HIV at a high risk of developing tuberculosis, a devastating infectious disease that is an integral part of prison environments.

"THE GLOBAL STATE OF HARM REDUCTION" AND OPIOID SUBSTITUTION TREATMENT IN PRISONS:

In spite of the international human rights frameworks calling for the right to health to be provided for people who use drugs, and for the same level of health care to be provided for people who use drugs who are incarcerated, states have largely failed to meet these standards. For example, in 2016 only 52 countries provided opioid maintenance treatment or substitution therapy in prisons. In a significant number of countries, OST is available only in a limited number of prisons and is frequently lacking in prisons for women. As for harm reduction, the situation of needle and syringe programs is worse, with only 10 countries providing such programs. Concerning overdose prevention training and distribution of opioid antagonists such as naloxone to people in detention prior to or at release from confinement, only five countries provide such training and distribution; although in the cases of Canada and the United States, this measure is further restricted to a limited number of provinces or states respectively.[54]

Tuberculosis

Tuberculosis is a disease caused by the mycobacterium tuberculosis bacillus. The disease is spread when people who are sick with pulmonary tuberculosis expel bacteria into the air that is then breathed in by other people. The risk of developing active tuberculosis increases dramatically when the immune system is compromised by HIV, drug use, alcohol, malnutrition, or poor living conditions. The risk of developing active tuberculosis can reach 30 per cent or more under these conditions.

The optimal way to prevent the development of active tuberculosis, and thus the spread of the infection, is to identify and treat those with so-called latent tuberculous infections, who are at risk of developing active forms of the disease. Unfortunately, this is rarely done in prison settings and data on prevalence of latent tuberculous infection in prisons is scarce. In Spain, a prevalence of latent tuberculous infection of approximately 55 per cent has been documented among those imprisoned in Madrid, compared to 15 per cent in the general population nationwide.[55] A similar pattern of latent tuberculous infection prevalence was also reported in Brazil.[56]

Prisons create particularly high-risk environments for the transmission of tuberculosis due to close contact between large numbers of high-risk individuals over extended time periods, overcrowding, and poor ventilation and hygiene. Furthermore, prison-associated risk factors, such as malnutrition, stress, HIV, hepatitis C and other comorbidities, and problematic drug and alcohol use promote transmission of mycobacterium tuberculosis between incarcerated people. Prison environments serve as a reservoir of tuberculosis and facilitate new infections where infection with mycobacterium tuberculosis progresses rapidly to become active tuberculosis or causes re-activations of latent tuberculous infections. Prisons, drug use, and HIV are all independent risk factors for the development of tuberculosis, yet when combined create a "perfect storm" by amplifying each other into a synergistic comorbid phenomenon.[57]

> There is a negative and mutually reinforcing impact of incarceration, drug use, tuberculosis, HIV and hepatitis. Overincarceration of people who use drugs creates a high-risk environment for diseases and their onwards transmission to the community after release.
>
> Michel Kazatchkine, member of the Global Commission on Drug Policy

Drug use and poor detention conditions: the "perfect storm"

Despite the existence of well-known preventable measures that are easy to implement, tuberculosis is one of the fastest-growing epidemics among prison populations and one of the main causes of death, particularly in low- and middle-income countries, where the prevalence of tuberculosis in the general population is also high. Indeed, prisons are recognized as critical social vectors for the transmission of tuberculosis into society, and a direct correlation between incarceration rates and tuberculosis incidence in the general population has been found.[58]

Data suggests that prisons contribute substantially to tuberculosis epidemics among the general population, but especially for people who inject drugs and especially in countries where tuberculosis is endemic. For example, in Ukraine, although only 0.5 per cent of the adult population was incarcerated, it has been estimated that 6 per cent of all new tuberculosis cases result from incarceration. Among people who inject drugs, this increases to 75 per cent for those living with HIV and to 86 per cent among those free from HIV.[59]

With treatment, tuberculosis is a curable disease. However, tuberculosis control in prisons is complicated by low cure rates due to delayed diagnosis; poor isolation facilities; treatment interruptions due to lack of drug supply or poor

GHAVTADZE V. GEORGIA (NO. 23204/07), OR THE OBLIGATION FOR STATES TO PROTECT THE PHYSICAL INTEGRITY OF PEOPLE INCARCERATED

In June 2009, the European Court of Human Rights (ECHR) found Georgia in breach of Article 3 of the European Convention on Human Rights (the prohibition of inhuman or degrading treatment). The case was put forward by Irakli Ghavtadze, a person who injects drugs, and who was arrested and sentenced to 11 years in prison on gun charges. A few weeks into his incarceration, the plaintiff started showing symptoms of viral hepatitis. He was taken out of hospital twice by penitentiary services, and was also infected with scabies and tuberculosis. While the ECHR could not establish whether the hepatitis infection occurred in prison, the court stated unanimously that the Georgian authorities violated the prohibition of inhuman treatment against Mr. Ghavtadze, confirmed his right to health, and mandated the authorities to place him immediately in treatment facilities able to address his infections with hepatitis B and C, as well as tuberculosis. Moreover, the judgment also required authorities to take appropriate individual and general measures to prevent the spread of contagious diseases in Georgian prisons, introduce a tuberculosis screening system for incarcerated people upon admission, and guarantee the prompt and effective treatment of these diseases.

adherence; and, in consequence, development of multi-drug resistant tuberculosis. People are often released into the community before treatment completion and without effective transitional care.[60] Transmission of tuberculosis to the community occurs not only after release, but also through visitors and prison staff. Findings from a modelling study in Brazil suggest that the prison environment, more so than the prison population itself, drives tuberculosis incidence, and targeted interventions within prisons could have a substantial effect on the broader tuberculosis epidemic.[61] Tuberculosis and HIV in prisons remain neglected public health and human rights issues in many countries worldwide, where the rights of incarcerated people to adequate health care are being violated and treatments are not available. Even where treatments are available, incarcerated people often tend to take medication irregularly, in order to become sicker and get an opportunity for transfer into a facility with better conditions.[62] Irregular treatment creates conditions for the development of multi-drug resistant tuberculosis (MDR-TB), which requires a longer treatment duration (up to two years, compared to six months for drug-sensitive tuberculosis), more toxic drugs, higher costs, and results in significantly lower cure rates.

The tuberculosis epidemic in prisons is a particular challenge for public health, and is an economic and social problem in sub-Saharan Africa, Eastern Europe and Central Asia.[63] Eastern Europe and Central Asia have the world's highest proportions of multi-drug resistant tuberculosis (MDR-TB) at 9 to 35 per cent of new tuberculosis cases and 49 to 77 per cent of re-treatment cases in Belarus, Russia, and Ukraine, compared with 1 to 3 per cent of new cases and 4 to 14 per cent of re-treatment cases in Italy, Switzerland, and the United Kingdom.[64]

Considering the prison environment and risk groups described above, there is a potential threat that the spread of MDR-TB between people detained, prison staff, and into the community will further increase unless urgent measures are taken. Strategies to reduce the incarceration of people who inject and/or use drugs would have the greatest impact. Opioid maintenance therapy, of which the positive effect on the health and behavior of people who inject drugs is well documented,[65] along with harm reduction services, should be widely implemented in prisons and be available to all in need. Expansion of prison-based OST with effective community transition after release could be an effective strategy to reduce transmission of tuberculosis, HIV, and hepatitis C. Prison workers need to be educated and trained in harm reduction and to view these

Testimony

Anonymous – Russia

I was placed in a pre-trial detention facility while I was suffering from withdrawal, as a consequence of being held in a department where a criminal case was initiated against me under Article 228 point 2. Withdrawal was so severe and painful that an ambulance was called, but, apart from giving me an injection of a mild anti-spasmolytic "No-Spa", the doctors didn't help much. I was taken into detention in the evening and, because I was constantly nauseous, I asked to call an ambulance. I received the following answer: "Are you fucking out of your mind, you junkie? Look how many of you are here – do you seriously expect us to call an ambulance for every single one of you?"

Later, I overheard their exchanges: "Maybe we should take him to Semyon?" I found out later that Semyon was the chief officer of the facility. I was then taken into quarantine for the recently arrested. The quarantine cell, initially intended for 21, held almost 70 inmates. We took turns sleeping on bunk beds three at a time. Cigarette smoke hung in the air. I introduced myself and explained that soon I will go into withdrawals. My fellow inmates were understanding: as it turned out, three quarters of the people there went through the same experience. People shared advice: they told me the best things to do and gave me a place to sleep. They really understood what I was going through.

On the first day, everything was more or less fine – I think that the overall stressful state I was in, the adrenaline, helped me to cope with the symptoms on the first day. On the second day, I was in hell. People in the cell around me helped as they could. On the third day, I asked for a doctor who only showed up two hours later! I complained about my health and he declared: "Are you fucking insane, you junky? If you dare call me again, I will send you to isolation." He gave me two Ketorolac (Toradol)* pills. Then I was very ill – I vomited all the time and I thought that was going to die. The inmates called the doctor again who came, looked at me, and did nothing.

Around the fifth or the sixth day, it got a little better, but I couldn't sleep. Sleep was basially just fainting for thirty minutes to an hour at a time. This lasted for about a month, a time during which I had called the doctor twice, both times to ask for medication to help me sleep. He refused, threatening to throw me in isolation or into a "looney-cell" (a cell for inmates with mental disorders).

About ten days later, they started taking me to the so-called "investigation-related activities" (interrogations, cross-examinations, etc.). Once, I was brought in for a talk with the chief officer who offered: "I have a deal for you. If you admit to breaking into the apartment (I was expected to plead guilty for breaking into an apartment and for a theft that I did not commit), I will give you 5 grams." I replied that I had to think about it. Obviously, I didn't want to do time for a crime I didn't commit, but my craving for drugs was bad. I was asked the question again a second time, and I categorically refused.

Overall, what I can tell you from this experience is that to find oneself in a Russian detention facility – without a single trace of humane conditions –constitutes a severe punishment in itself. To be held there while in withdrawals is torture, pure and simple! The medical staff – if there's any at all – gives you no assistance. The only thing that does help is the mutual support of the fellow inmates who understand the situation.

* A nonsteroidal anti-inflammatory drug used to treat pain.

TUBERCULOSIS ELIMINATION AND THE SUSTAINABLE DEVELOPMENT AGENDA :
AN AIM IN SEARCH OF POLITICAL WILL

With the adoption of the Sustainable Development Goals (SDGs) in 2015, the international community pledged to "end the epidemic of tuberculosis (TB) by 2030" by reducing its incidence among all populations.[67] With 1.3 million deaths annually, tuberculosis is currently the leading cause of death from infectious disease in the world. Its incidence has declined at an annual rate of 2 per cent over the last 15 years, whereas its elimination by 2030 requires a decline of 4 to 5 per cent per year.[68] In prison, the levels of tuberculosis are reported to be 100 times higher than in the general population, and up to 24 per cent of all tuberculosis cases in prison could be MDR-TB.[69] Moreover, it is estimated that less than 5 per cent of all countries will be able to eliminate tuberculosis by 2030.[70]

Due to the lack of effective measures to control TB, the concentration of almost half of TB cases in BRICS countries, and with a third of antimicrobial resistance (AMR) deaths related to TB, tuberculosis has been on the political agenda of the G20 since 2017, and the international community approved the first political declaration on TB in September 2018.[71]

measures as a high priority.[66] There is also a need to develop cost-effective interventions to diagnose, treat, and prevent tuberculosis transmission among the incarcerated population.

"A prohibitionist approach [to drug policy] is mandated by the UN conventions, which refer to drug addiction as an 'evil'. It is a short step from that to seeing those who use drugs as evil and deserving of punishment."

Helen Clark, member of the Global Commission on Drug Policy, Auckland, March 2019

THE RIGHT TO HEALTH IN PRISONS: OBLIGATIONS UNDER INTERNATIONAL LAW

The right to health is applicable to all people on a non-discriminatory basis, which means that people who use drugs and drug-dependent people cannot be subjected to discrimination in the provision of health care. Indeed, the right to health extends to assessment and treatment for drug dependency, and harm reduction services have been recognized as part of the right to health for people who use drugs.

According to the Mandela Rules (the UN Standard Rules for the Treatment of Prisoners), the provision of health care for those incarcerated is a state responsibility, and incarcerated people should enjoy the same standard of health care as that available in the community, free of charge and without discrimination on the grounds of their legal status (Rule 24, para. 1). The provision of health care in prisons to the same standard as that available in the community has also been advocated by WHO. Health care should be organized in close relationship with the general public health administration, and in a way that ensures continuity of treatment and care, including for HIV, tuberculosis and other infectious diseases, as well as for drug dependence (Rule 24, para. 2). The Mandela Rules also have a provision that the physician or other qualified health care professional who examines each incarcerated individual as soon as possible following his or her admission, and thereafter as necessary, shall focus particular attention on symptoms of withdrawal from the use of drugs and undertake all appropriate individualized measures and treatment (Rule 30).

The Bangkok Rules (the UN Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders), which are designed to complement the Mandela Rules, state

that the state should provide for gender-sensitive, trauma-informed, women-only treatment programs in the community (Rule 62).

With respect to children who use drugs, the Committee on the Rights to the Child (in its general comment No. 15, 2013) endorsed harm reduction as an important approach to minimizing the negative health effects of substance use. It has recommended that children receive accurate and objective information on drugs and that they should not be subject to criminal proceedings. The committee has called for the possession of drugs by children to be decriminalized.[72]

POORLY PREPARED PRISON-RELEASES AND HEALTH RISKS

A major challenge for countries is not only to improve health care and harm reduction services dramatically for drug-dependent people in prisons and other detention centers, but also to coordinate health care management for incarcerated people who are drug-dependent on release with health care providers in the community. The individual leaving prison with a continuity of health care in the community has a greater chance of positive health outcomes, especially when the risks of overdose deaths are very high after release.

In Ontario, one in 10 overdose deaths happens to former inmates within a year of release. The risk of overdose death is extremely high in the first two weeks of release, and has been estimated at 56 times the risk in the general population. Indeed, it has been posited that the forced break from drug use while in prison lowers the tolerance of incarcerated people, and that even if they were able to procure and use drugs while in prison, the drugs they can procure and use after release are stronger.[73] Other studies have made similar findings. For example, a study in North Carolina in the United States found that people formerly incarcerated were 40 times more likely to die of an opioid-related overdose than someone in the general population. Moreover, when restricted to heroin-related overdose deaths only, the likelihood of death increased to 74 times higher compared to the general population in the first two weeks after release.[74]

More than 80% of all detainees in Haiti are being held in prolonged pretrial detention during which detainees can wait between four and six years for their court cases to be heard. © UN Photo/Victoria Hazou 2012

Inmate of a compulsory drug detention center in the northern city of Hai Phong, Vietnam

© HOANG DINH NAM/AFP/Getty Images 2017

COMPULSORY DRUG DETENTION CENTERS AND ADMINISTRATIVE DETENTION

STATE-RUN COMPULSORY DRUG DETENTION CENTERS

Compulsory drug detention centers have been variously called compulsory treatment centers, drug rehabilitation centers, compulsory detoxification centers, or centers for social education and labor.[75] Such facilities are settings where individuals who use drugs, or who may only be suspected of using drugs, are confined against their will with the objective of constraining them to abandon the use of drugs. In most cases, there is no clinical evaluation of whether they encounter problematic drug use or not. There is usually no or little legal process associated with the confinement, and no appeal process.

Large-scale compulsory drug detention centers originally gained prominence in East and Southeast Asia. One source estimated that 450,000 people were confined in seven countries (Cambodia, China, Lao People's Democratic Republic, Malaysia, the Philippines, Thailand, and Vietnam) in 2014.[76] Another source estimated the number of detainees in various centers in the region at 600,000.[77] These numbers may actually underestimate the number of people in confinement in compulsory drug detention centers worldwide, as they have been found in at least 15 states (Brunei, Cambodia, China, Egypt, Indonesia, the Islamic Republic of Iran, Lao People's Democratic Republic, Malaysia, Myanmar, the Russian Federation, Saudi Arabia, Singapore, Sri Lanka, Thailand, and Vietnam).[78]

Procedures for committing people who use drugs, or allegedly use drugs, vary from country to country. Detention is based on administrative law in some countries and criminal law in others. Individual arrests by law enforcement, mass arrests in major drug crackdowns, testing positive for drugs in a urine test, or being turned over by family or community members, can all lead to detention.

In the case of states where administrative law is the basis for confinement, detainees may be designated as victims, patients (e.g. Cambodia, Laos, Thailand),[79] or people engaged in behavior considered as a social evil (e.g. Vietnam). In countries such as Cambodia and Laos, it has been reported that those detained for drug use have been kept in facilities with other people deemed "undesirable" by society, such as people with problematic alcohol use, homeless people, sex workers, and people with mental disabilities.[80]

Human rights abuses that have been reported in compulsory drug detention centers include arbitrary detention, beatings, whipping, other physical and verbal abuse, torture and other forms of ill treatment, sexual violence, forced labor, solitary confinement, denial of adequate health care, deplorable living conditions characterized by poor ventilation and sanitation, overcrowding, and poor nutrition. Beatings in response to minor infractions of the rules can be severe, and reports have indicated that they can result in broken limbs or rendering the person unconscious. There have also been reports of detainees being tied up for hours in the sun without food or water.[81]

Thousands of children are also detained in such facilities. Family members may request local authorities to detain children suspected of using drugs, because they believe detention centers to be therapeutic (against scientific evidence), or they may be picked up in operations by law enforcement in an attempt to "clean the streets." In some cases, they may be detained because they are the children of homeless people or beggars found during drug enforcement operations. The detention of children violates human rights in a number of ways: it is considered arbitrary, since detention of children should only be a measure of last resort, and they should not be housed with adults; and any deprivation of liberty shall only take place after "the juvenile is adjudicated of a serious act involving violence against another person or of persistence in committing other serious offenses, and unless there is no other appropriate response, according to the UN Standard Minimum Rules on the Administration of Juvenile Justice."[82]

In China, repeat offenders who have first been in community treatment programs can be held in compulsory drug detention centers for two years, with flexibility allowing for early release or an additional year in detention. In Vietnam, initial detention

COMPULSORY DETENTION AND EFFECTIVE DRUG TREATMENT: ANTAGONISTS IN MALAYSIA

When comparing health outcomes of compulsory drug detention centers to voluntary centers in community settings that use evidenced-based methods, the differences are extraordinary. In Malaysia, where the two systems exist side-by-side, participants in one study included 89 people from compulsory centers and 95 from voluntary centers, all of whom who were found to have problematic opioid use. The participants had drug tests and interviews on entry to the centers and repeatedly after release (at one, three, six, nine and 12 months after release).[90] People held in compulsory centers relapsed at a much higher rate than those from voluntary centers. One month after release, 51 per cent of those from compulsory centers were opioid-free, compared with 90 per cent of those from voluntary centers.[91] After six months, only 19 per cent of those from compulsory centers were opioid-free, compared to 69 per cent from the voluntary centers. At the voluntary centers, people were assessed at the time of entry into the program, placed on methadone, and then allowed to use a variety of treatments, including psychosocial counselling and recreational activities.

The main difference between those who were held in compulsory centers and those who attended the voluntary centers was that methadone was available as part of an opioid substitution therapy at the voluntary centers, whereas it was not at the compulsory centers. In spite of the radically different outcomes between the two different approaches in Malaysia, the study noted that compulsory drug detention centers in Malaysia continue to exist because of a zero-tolerance attitude in the country to drug use, and a lack of recognition of the effectiveness of voluntary centers compared to the ineffectiveness of compulsory ones. [92]

may last two years, but can be extended for another two years following an evaluation of the detainee. In Malaysia, a person with a positive urine test and who is deemed to be drug-dependent by a government medical officer can be detained for up to two years, although a mean period of detention of 7.5 months was cited in one study.[83]

While the approach varies slightly from country to country, compulsory drug detention centers generally regard the use of drugs as a matter of free will, and therefore focus on trying to change the personality of the detainee so that he or she will abandon drug use. Detainees in compulsory drug detention centers are often subjected to long hours of physically strenuous and exhausting exercise. Other compulsory drug detention centers provide spiritual counselling to detainees.[84,85] In addition to military-style strenuous physical exercise programs and harsh discipline, compulsory drug detention centers in some countries also require forced labor (e.g. Cambodia, China, and Vietnam),[86] which has sometimes been referred to as labor therapy. Detainees are obliged to work long hours, either with no pay or pay significantly below market rates.[87] In some cases, this work is dangerous or physically arduous, such as in construction or agriculture, and often no proper protective gear is provided. Forced labor for the manufacture of clothing, shoes, and handicrafts has also been reported. Children who are detainees and incarcerated with adults may also be required to perform forced labor.[88]

"In a number of countries, nearly half or more of the prison population comprise people who use drugs, for whom incarceration has no effect in reducing or altering drug use patterns. Such wasteful policies are a huge burden on the taxpayers."

Anand Grover, member of the Global Commission on Drug Policy, South Africa, August 2017

Relapse rates for people released from compulsory drug detention centers are very high. For example, very high relapse rates have been reported in Cambodia and China, with more than 90 per cent of people who use heroin relapsing after release.[89] UNODC and WHO have stated that "the human rights of people should never be restricted on the grounds of treatment and rehabilitation" and that "inhumane

or degrading practices and punishment should never be part of treatment of drug dependence."[93] They have also indicated that "neither detention nor forced labor have been recognized by science as treatment for drug use disorders."[94] Moreover, in 2012, 12 UN entities issued a joint statement through the UN Joint Program on HIV/AIDS, calling for the closure of compulsory drug detention centers.[95]

Health outcomes of compulsory drug detention centers, as is well documented, result in high rates of relapse within a year of release, while health outcomes of voluntary treatment in community settings using evidenced approaches result in low relapse rates. Nevertheless, data indicates that states have been reluctant to change their approach and close compulsory detention centers, despite calls by the UN, medical experts, and civil society. Although the population of compulsory drug detention centers decreased by 4 per cent between 2012 and 2014 in East and Southeast Asian countries, subsequent data through 2018 indicates that there have been no significant decreases in some countries, while there has actually been an increase in others.[96]

COMPULSORY DETENTION IN PRIVATE DRUG TREATMENT CENTERS

Although compulsory drug detention centers operated by states have received much attention, an equally troubling issue concerns private drug treatment centers that engage in practices that violate international law and in many cases national law as well.

The state has an international obligation to prevent human rights violations, to ensure respect and protection of human rights, and to provide a remedy when violations occur. These obligations are not limited to state action, but also include institutions such as private drug treatment centers. The state has an obligation to ensure that no one is coerced against their will into a private drug treatment center, and that any treatment is based on informed consent; evidence-based health care is practiced; the crime of torture is not being perpetrated; that other forms of cruel, inhuman, and degrading treatment or punishment are not practiced; people are being treated with humanity and respect for their dignity; and that the rights to

DRUG COURTS AS A FORM OF COERCION

Coercive entry into private facilities may result from the actions of drug courts. A number of countries have implemented so-called drug courts – most notably the US, which has over 3,000 such courts – as a way to stop incarcerating low-level drug offenders by diverting them into court-supervised treatment programs. While seemingly a more compassionate approach, drug courts are deeply flawed.

In Latin America and the Caribbean, drug courts provide those charged with a drug-related offense, including drug use or possession, with a choice between imprisonment or drug treatment. While drug treatment centers can be public in some countries, in many countries in Latin America and the Caribbean they are overwhelmingly private. For example, Mexico has around 2,000 residential treatment centers, but only 43 are public. In Puerto Rico, 85 percent of residential treatment facilities are operated by private entities.[101]

Both WHO and UNODC have acknowledged that coercion is present in the decision-making process, but have argued that the individual still has a choice.[102] The Office of the High Commissioner for Human Rights has argued that any decision to have treatment is coercive if the alternative is prison, and that such coercion is a violation of the right to health.[103] In addition, treatment may not be necessary because some participants may not be dependent.[104]

The Global Commission reiterates its position in previous reports that drug courts are a conceptually flawed and insufficient approach.[105] Drug treatment should be a matter for health professionals working in the health sector and should never involve the criminal justice system. Coercing people into treatment through the threat of a criminal sanction is wholly unethical and counterproductive. It is concerning that drug courts are becoming increasingly common in the Caribbean and Latin America as the US, through the Organization of American States, promotes this extremely controversial approach.

life, privacy, and to food, water, and sanitation, are protected. In practice, this means that states have an obligation to register and authorize the operations of private drug treatment centers; to set minimum standards of conduct and care at such facilities; to conduct regular inspections, including surprise inspections; to undertake prompt, impartial, and effective investigations when there are complaints of human rights violations; and to sanction non-compliant facilities up to and including closure.

Several studies have found that many human rights violations occur at such facilities in a number of countries and territories in Latin America and the Caribbean, including Brazil, Chile, Colombia, Costa Rica, the Dominican Republic, Guatemala, Mexico, Panama, and Puerto Rico.[97] People are frequently brought to these private facilities against their will by family members, law enforcement officials, or staff of private centers. It has been reported that these centers try to intimidate people into signing consent forms by threating them and their families if they refuse to do so.[98] Once in these facilities, it may be difficult to leave. In some facilities, attempts to leave without authorization are severely punished, including by beatings or other physical abuse.[99]

The private drug treatment centers reviewed in the studies of Latin American and Caribbean countries and territories view drug use and drug dependency largely as a moral failing. They overwhelmingly use an abstinence-based approach to treatment. This approach is frequently combined with harsh discipline, cruel punishments, humiliation, confrontational therapy, and in the case of church-run facilities, an appeal for people who use drugs to discover a new-found belief in God as a way to abandon drug use. The strict disciplinary approach often results in beating, kicking, and other forms of physical abuse for minor infractions of the rules, which sometimes has resulted in loss of life.[100]

ADMINISTRATIVE DETENTION

Administrative detention can take several forms. Perhaps the best-known form of administrative detention is a decision by the state to detain a person because his or her drug use is considered to constitute either a danger to themselves or to others. This type of administrative detention is found in a number of states and is most frequently provided for under psychiatric legislation, rather than legislation applicable to drug use. In a joint document, WHO and UNODC stated that compulsory treatment may be legally permitted "only in exceptional crisis situations of high risk to self or others," but added that "neither detention nor forced labor have been recognized as treatment for drug use disorders."[106] However, such a standard, even with its qualifications, is problematic because it conflicts with the human rights standard that health care must be based on voluntary and informed consent, and that a person has the right to refuse treatment and leave a treatment setting.

Pregnant women

Another area where administrative detention is practiced concerns pregnant women who are drug dependent. In Norway, for example, a 1996 law authorizes the authorities

ADMINISTRATIVE DETENTION IN SWEDEN

The Swedish Care of Persons with Substance Use Disorders in Certain Cases Act states that if as a consequence of continuing problematic drug use anyone is placing their physical or mental health in serious danger, is running a clear risk of destroying their life, or if there is a fear that they may seriously harm themselves or a person close to them, a court may decide on compulsory care, provided that the care cannot be carried out in any other way. The purpose of compulsory care under this Swedish law is to motivate the individual to seek voluntary treatment for a limited period of time (a maximum of six months). According to the Swedish government, 75 per cent of those who are subjected to compulsory care choose to transfer to voluntary treatment.[107]

to detain a woman who is drug dependent in in-patient treatment without her consent if the situation of her drug use makes it reasonably likely that the fetus could be harmed and if voluntary health measures are insufficient. In this context, the fetus is favored over the woman's right to liberty because of the potential risk of harm. Nevertheless, the Norwegian case appears to be an isolated one, at least in Europe. [108]

In the US state of Wisconsin, a 1997 law permits the state to take into custody a pregnant woman who "exhibits a habitual lack of self-control over her drug use" if the state determines that she presents a "substantial risk" to the "physical health of the 'unborn child.'" In 2017, the US Supreme Court vacated a lower court stay blocking enforcement of the law, and ruled that the state may continue to enforce the law until the appeals process was completed.[109] Other states in the United States have restrictions that may threaten pregnant women who use illegal drugs with criminal sanctions, require doctors to report prenatal drug exposure, or consider prenatal drug exposure as a factor in child welfare legal determinations, which can lead to termination of parental rights on the grounds of child abuse or neglect.[110]

While the use of illegal drugs can have harmful effects on a fetus, legal sanctions, restrictions, and reporting requirements concerning pregnant women who use drugs have generally been resisted by health advocates. They argue that problems associated with pregnant women who use drugs or who are drug dependent should be dealt with by health professionals, and that legal sanctions, restrictions, and reporting requirements will drive pregnant women who use drugs away from vital health services, and jeopardize their well-being and right to health.[111] WHO has published guidelines for the identification and management of substance use during pregnancy. [112]

Undocumented migrants

Another area where administrative detention is applicable concerns people who use drugs and who are detained as undocumented migrants, as well as those subject to deportation orders. The time of confinement in immigrant/deportation facilities varies considerably from country to country. In some countries, it may approximate 30 days or fewer, while in others it may be for much longer periods.

It was reported that drug use and drug dealing were widespread in an immigration removal center in the United Kingdom. In addition, a significant degree of violence was reported at the facility, and detainees were reported to inflict self-harm, including attempted suicide.[113] A contributing factor is that those with serious criminal records are mixed with immigration offenders and applicants for asylum.[114]

At Australia's largest detention facility, used both for immigration removals and undocumented migrants seeking refugee status, it was reported that drugs were widely available. Because of the stressful environment in the detention facility, potential deportees and migrants resorted to substance use to deal with the difficult situation.[115]

In the United States, there has been a sharp increase in detention of undocumented migrants in recent years, rising from 6,800 in 1994 to 40,500 in 2017. A major criticism of government policy has been a lack of adequate health care for those in administrative detention.[116]

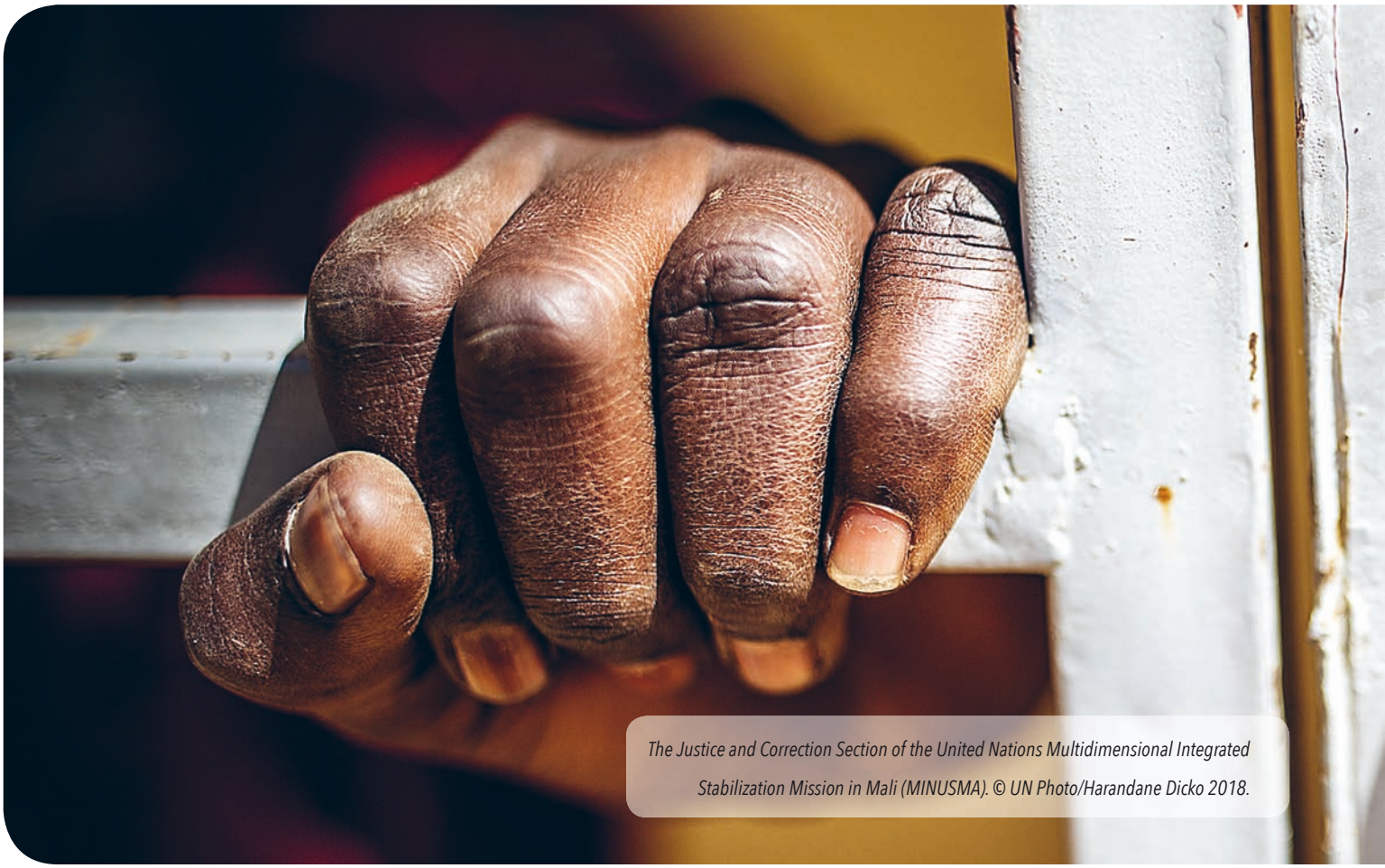
At some US government-funded youth shelters, children were regularly given, and in some cases compelled to take, a range of psychotropic drugs to manage their trauma after being detained, and in several instances separated from their parents. It was alleged in 2018 that children were given substances when their condition did not require it and without their parents' consent.[117] After a lawsuit challenging these practices, a federal court ordered the US government to seek consent from immigrant parents before their children were administered psychotropic drugs.[118]

POLICY RECOMMENDATIONS FROM THE GLOBAL COMMISSION

The levels of incarceration over the last 30 years are unprecedented in times of peace and do not correspond to a similar increase in crime or criminal activity, but are instead caused by the increasing reliance of justice systems on incarceration as means of harsh punishment. This overreliance on incarceration is creating short- and long-term challenges for societies, ranging from disproportionate sentences to over-incarceration, especially of people from poor and marginalized communities, and favoring incarceration for minor offenses rather than other serious crimes (such as financial crimes). Incarceration also results in higher rates of morbidity and mortality for incarcerated people, with their vulnerability to infections (particularly tuberculosis and drug-resistant forms of tuberculosis) and injuries increasing once they have been arrested.

The current levels of incarceration prevent countries from fulfilling their human rights and international obligations with regard to their incarcerated populations. Since 2011, the Global Commission on Drug Policy has called for reviews of the current criminal justice and correctional systems globally, to favor alternatives to incarceration, to end disproportionate sentences, and to decriminalize drug use. Following this pathway will move us away from the harms of punitive drug policies toward policies centered on justice, dignity, and human rights for all.

RECOMMENDATION 1: States must end all penalties – both criminal and civil – for the possession and cultivation of drugs for personal consumption. Millions of people around the world use drugs and do so without causing any harm to others. To criminalize people who use drugs is ineffective and harmful, and undermines the principle of human dignity and the rule of law. States must implement alternatives to punishment, such as diversion away from the criminal justice system, for all low-level, non-violent actors in the drug trade, such as those engaging in social supply, drug couriers, user-dealers, and cultivators of illicit crops.



The Justice and Correction Section of the United Nations Multidimensional Integrated Stabilization Mission in Mali (MINUSMA). © UN Photo/Harandane Dicko 2018.

RECOMMENDATION 2: States must end disproportionate sentencing and punishment for drug-related offenses, and recognize that over-incarceration impacts negatively on public health and social cohesion. The never-seen-before level of overreliance on incarceration observed globally in the last decades has negatively impacted public health, social cohesion, and many other global development objectives. Deprivation of liberty is the wrong response to drug use and to non-violent petty crime generated by the illegal market.

RECOMMENDATION 3: States must ensure primary health care is available and the right to health is applicable to all people on a non-discriminatory basis, including people detained against their will. Incarcerated people, people who use drugs and drug-dependent people must not be subjected to discrimination in the provision of health care. The right to health extends to assessment and treatment for drug dependence, and harm reduction means have been recognized as part of the right to health for people who use drugs. Health care must be based on confidentiality. People confined in compulsory drug detention facilities should be released and, for those detainees concerned, encouraged to seek evidence-based and tailored treatment for drug dependence in voluntary centers in community settings

RECOMMENDATION 4: Practices that violate human rights of people deprived of liberty must be forbidden, their perpetrators brought to justice, and compensation awarded to victims as provided for in human rights law. These practices include, but are not limited to, torture, cruel, inhumane and degrading treatment or punishment, overcrowding, confinement, forced labor, arbitrary and unlawful detention, and violations of the right to security of the person, the right to be treated with humanity and respect for one's dignity, or the right to adequate food.

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ADDITIONAL RESOURCES

www.anyoneschild.org
www.beckleyfoundation.org
www.countthecosts.org
www.druglawreform.info
www.drugpolicy.org
www.genevaplatform.ch
www.hri.global
www.hrw.org
www.intercambios.org.ar
www.icsdp.org
www.idhdp.com
www.idpc.net
www.inpud.net
www.incb.org
www.menahra.org
www.ohchr.org/EN/HRBodies/HRC/Pages/WorldDrugProblem.aspx
www.politicadedrogas.org/PPD
www.sdglab.ch
www.talkingdrugs.org
www.tdpf.org.uk
www.unaids.org/en/topic/key-populations
www.unodc.org
www.wola.org/program/drug_policy
www.wacommissionondrugs.org
www.who.int/topics/substance_abuse/en/

REPORTS

http://www.globalcommissionondrugs.org/reports/

- War on Drugs (2011)
- The War on Drugs and HIV/AIDS: How the Criminalization of Drug Use Fuels the Global Pandemic (2012)
- The Negative Impact of the War on Drugs on Public Health : The Hidden Hepatitis C Epidemic (2013)
- Taking Control: Pathways to Drug Policies That Work (2014)
- The Negative Impact of Drug Control on Public Health : The Global Crisis of Avoidable Pain (2015)
- Advancing Drug Policy Reform : a New Approach to Decriminalization (2016)
- The World Drug Perception Problem: Countering Prejudices against People Who Use Drugs (2017)
- Regulation: the Responsible Control of Drugs (2018)

POSTION PAPERS

http://www.globalcommissionondrugs.org/position-papers/

- The Opioid Crisis in North America (October 2017)
- Drug Policy and the Sustainable Development Agenda (September 2018)

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GLOBAL
COMMISSION ON
DRUG POLICY

GLOBAL COMMISSION ON DRUG POLICY

The purpose of the Global Commission on Drug Policy is to bring to the international level an informed, science based discussion about humane and effective ways to reduce the harms caused by drugs and drug control policies to people and societies.

GOALS

- Review the base assumptions, effectiveness and consequences of the "war on drug" approach
- Evaluate the risks and benefits of different national responses to the drug problem
- Develop actionable, evidence-based recommendations for constructive legal and policy reform